Franklin Family Smiles PC

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Welcome to our Practice

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ________________________________ **Best time to call:** ____________________

Phone: ____________ ____________ ____________ ______ ____________ ____________
Home Mobile Work Ext Fax Other

Address: ________________________________ ________________________________
Address 1 Address 2

________________________________ ______ _____-____
City State Zip Code

WE WILL BE SENDING BILLING STATEMENTS VIA E-MAIL
PLEASE LET US KNOW IF YOU WOULD PREFER PAPER STATEMENTS

WOULD YOU LIKE ACCESS TO YOUR PATIENT PORTAL? ◯ Yes ◯ No

Whom may we thank for referring you to our practice?

Referral Name: ____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

____

____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________ **Phone:** ____________

Employer Address: ______________________ ______________________

Address 1 Address 2

______________________ ________ _____-____

City State Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ____ ______________

Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ______________

Email Address: ______________________ **Best time to call:** ______________

Phone: __________ __________ __________ ______ __________ __________

Home Mobile Work Ext Fax Other

Address: ______________________ ______________________

Address 1 Address 2

______________________ ________ _____-____

City State Zip Code

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________

ID #: ________________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insurance Company Phone Number:

____

____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

____

____

Previous Dentist Name and Phone Number:

____

____

Date of most recent dental exam and dental x-rays:

____

____

Is there anything about the appearance of your smile that you would like to change?

____

____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

____

____

____

____

Consent for Services and Financial Policy

I hereby authorize Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize providers to perform any and all treatment deemed necessary by Doctor - these procedures include, but are not limited to;examinations, oral prophylaxis (cleanings), restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions and the use of local anesthetics. I understand that the use of anesthetic agents embodies a certain risk. This consent shall be considered in effect until rescinded or revoked.

Patients understand that payment for all dental services charged are the sole responsibility of the patient. This office will prepare and submit the patient's insurance form and will credit any collections made from the insurance company to the patient's account.

HIPAA Acknowledgement

I understand that I may request a copy this office's HIPAA Privacy Practices notice.

Name and Relationship to Patient:

____

____

Signature ________________________

Response Date: ___________